Overview of the proposed plan

What is the new NYCE PPO?

The NYC Employees PPO Plan (NYCE PPO) is a new premium-free health plan offered jointly by EmblemHealth and UnitedHealthcare. It would include health coverage for doctors, hospitals and other medical facilities — all under one health plan and one member ID card. The current in-network copays — the flat fee we pay for visits with contracted doctors — would remain the same, while the network of providers would expand. This plan would be available to all city employees, pre-Medicare-eligible retirees and their eligible dependents enrolled through the NYC Health Benefits Program. Coverage would begin on Jan. 1, 2026. This plan, if approved, would replace the current GHI CBP plan for in-service members and pre-Medicare retirees. No other city health plans would be affected.

Is EmblemHealth different from GHI CBP?

EmblemHealth is the insurance company that administers the medical portion of the current GHI CBP plan. Your medical health insurance card now says EmblemHealth at the top and it would continue to say EmblemHealth under the NYCE PPO. The continuing participation of EmblemHealth is a big benefit of this new plan.

Anthem (formerly BlueCross BlueShield) administers the hospital portion of the GHI CBP plan. Therefore, members have two ID cards for the GHI CBP plan: an EmblemHealth card for medical coverage and an Anthem card for hospital coverage. The new plan streamlines medical and hospital coverage into one network with one ID card (see below).

How is the new NYCE PPO different from the GHI CBP plan?

The new plan would include health coverage for doctors, hospitals and other medical facilities — all under a single health plan. Here are a few other key differences:

- Members would receive a single ID card — replacing the current system of two separate plans and two ID cards.
- EmblemHealth would provide coverage for doctors and hospitals in the DS13. The new plan's network in the DS13 would include 78,000 providers, an increase of 14,000 providers.
    - 97% of these providers would have availability to see new patients.
- UnitedHealthcare would provide national coverage for doctors and hospitals outside EmblemHealth's covered area through its national network of 1.6 million providers, up from about 120,000 in the GHI CBP plan.

- All your health information and documents would be in one place in a single member portal.

Is there anything in the GHI CBP plan that isn't included in the new plan?

No. All the benefits and services that we have in our current plan would be offered in the NYCE PPO, plus more features and enhancements.

Would we still have access in this plan to our same EmblemHealth providers in the Downstate 13 counties (DS13), which are made up of New York City, Long Island and Dutchess, Orange, Putnam, Rockland, Ulster and Westchester counties?

Yes, providers who are currently contracted with EmblemHealth in these locations would also be covered under the NYCE PPO.

Are copays changing?

No, they are not. Each year we have to fight to stop insurance companies from increasing our copays. Under the proposed plan, our copays would stay the same as they are now, and more services would have no copays. NYC Health + Hospitals would join ACPNY as an in-network preferred provider which would expand the options across the city for medical services with no copays. This plan would help to protect our current rates for the next five years.

What mental and behavioral health services would the new plan provide?

Mental and behavioral health services will now be provided by United Healthcare. Through the new plan, members would continue to have in-person and virtual access to a nationwide network of quality behavioral health providers offering evidence-based treatment options. The proposed plan would include:

- 39,000 mental and behavioral health providers in New York State, which represents a 325% increase from the 12,000 providers in the GHI CBP plan.
    - 87% of which would be accepting new patients.
- 418,000 mental and behavioral health providers nationwide, which represents a 685% increase from the 61,000 providers in the GHI CBP plan.
    - 84% of which would be accepting new patients.
    - 85.5% of which practice both in person and virtually.
- Access to 22 specialty mental and behavioral health provider organizations, up from the seven offered in the GHI CBP plan. These organizations, which would provide

virtual services to members, would be accessed through EmblemHealth concierge services under the NYCE PPO. Examples include:

- Charlie Health for teens and adults who need mental health, substance use disorder or eating disorder-specific care
- Hazelden Betty Ford for virtual/digital therapy for substance use disorders
- InStride Health for virtual/digital therapy for pediatric anxiety and obsessive-compulsive disorders (OCD)
- Talkspace for virtual/digital therapy via texting, video or chat with licensed therapists

What other types of specialty health care programs would be offered in the new plan?

A suite of programs and resources would be offered on topics including wellness, disease management, maternity care, convenient virtual care and more. Details on these programs will be available if the plan is approved.

Would I need to get referrals from my doctor to see specialists?

No, the NYCE PPO would not require referrals.

What protections are in place to ensure the expanded network remains in place?

- The provider network in the DS13 would not drop below 74,000.
- At least 90% of all services inside the DS13 must be in-network.
- At least 95% of all services outside the DS13 must be in-network.
- EmblemHealth/UHC would commit to bring highly utilized out-of-network providers into the network.

Can this health plan be altered without MLC approval?

No. Any changes to the proposed health plan would need to be approved by both the city and the Municipal Labor Committee before they could take effect.

I have heard that the new city plan is a self-funded insurance plan. What does that mean?

In a **self-funded plan**, the **employer** (**in our case, the City of New York**) pays the medical bills directly when claims come in. "Self-funded" does not mean that individual members are paying their own medical bills. The "self" is the city in our case.

The insurance company is still there, but now they're acting as the administrator — processing claims, running the network of doctors and hospitals, and providing customer service.

This has no effect on us and the health care we receive. You will still use your health insurance card, go to doctors and hospitals, and pay the copays and deductibles like you're used to.

Moving to a self-insured plan from the current plan — which is technically a “minimum premium” plan — allows more flexibility in our case, with larger provider networks and fewer denials, since it's not about what makes an insurance company money, but about meeting negotiated standards.

Does "self-funded" mean that the plan is not subject to Department of Financial Services oversight?

No. NYCE PPO would be fully protected by law. The New York City Department of Financial Services (DFS) does not have direct oversight of self-funded plans (as they are not an “insured” product), but the agency still has oversight of EmblemHealth and UnitedHealthcare. The new health plan must comply with state and federal mandates, and consumers can still go directly to the Department of Financial Services with complaints.

NYCE PPO must also follow state consumer protection laws, including grievance and appeals processes. The proposed plan maintains internal grievance and appeal rights, as well as the ability to further appeal externally. In addition, plan members may file complaints directly with the Department of Financial Services even before completing the internal appeals process.

Does self-funded change what NYCE PPO is required to cover as a result of state and federal mandates?

No. **NYCE PPO must follow New York State and federal mandates regarding benefit coverage**. Because the MLC insisted that NYCE PPO be based on the laws of New York, the plan must comply not only with federal mandates, but also with state mandates on benefit coverage, such as prescription drug formularies and preventive care standards. Further, because ERISA does not apply to government plans, the state can enforce its own insurance laws, including:

- **Mental health parity**: Mental health coverage must be equivalent to physical health benefits
- **Autism spectrum disorder services**: Required coverage for diagnosis and treatment

- **Infertility treatment mandates**: Certain plans must cover medically necessary infertility services
- **Prescription drug coverage standards**: Plans must follow state formulary and access rules
- **Gender-affirming care**: Plans must cover surgery for participants who are 18 or older.
- **Reproductive health**: Plans must follow state mandates with regard to access and costs.

What is the benefit of a self-funded plan?

Self-funded benefit plans are very common with large employers, including many large unions across the country. A primary benefit of a self-funded plan is the flexibility in plan design.

Remember: all changes to any plan design are still subject to collective bargaining. Unions have a seat at the table to both advocate for improvements and fight back against any attempts to diminish benefits in the future.

I have heard the city is saving money with this new health plan. How is it possible to save money and still provide quality health care?

We leveraged the massive buying power of the entire Municipal Labor Committee to tell insurance companies to offer us high-quality health care at lower prices. They were willing to do this because getting our business is a massive win; the MLC represents 750,000 city workers, pre-Medicare city retirees and their dependents in the GHI CBP plan alone.

Let's say a contract with the MLC is worth $10 billion. We told insurance companies that they could get our business for $9 billion or not get our business at all. Of course, they chose to get $9 billion. This is what enabled us to maintain and improve our benefits while reining in costs for the city. The insurance companies didn’t want to walk away from 750,000 customers so we were able to reach a deal that met our needs.

Doctors

Will our current GHI-CBP EmblemHealth doctors be part of the new city health plan?

Yes. All providers who are currently contracted with EmblemHealth (GHI) in the Downstate 13 counties (DS13), which is made up of New York City, Long Island and Dutchess, Orange, Putnam, Rockland, Ulster and Westchester counties, would also be covered under the NYC Employees PPO plan.

Remember: At this moment, doctors are not aware of the NYCE PPO because it has only just been tentatively agreed to. It will not become an official plan until the MLC votes to approve it and it goes through a finalization process. Therefore, these doctors cannot answer any questions about NYCE PPO right now.

If you still wish to ask your doctor about the new plan before it is adopted:

For the Downstate 13, ask if they are in:

- EmblemHealth
- EmblemHealth Bridge Network

Outside the Downstate 13 (i.e., New Jersey and nationwide), ask if they are in:

- United Healthcare Choice Plus

For mental or behavioral health care providers, ask if they are in:

- UnitedHealthcare Behavioral Health Network

If the answer is yes, they will be part of the NYCE PPO.

What about doctors in New Jersey, Connecticut and outside the Downstate 13 counties in New York State?

The current GHI CBP plan has a limited network outside the Downstate 13 counties — only about 29,000 providers. Under the proposed NYCE PPO, members living outside the Downstate 13 would now have access to 1.6 million providers nationwide through the UnitedHealthcare Choice Plus network.

For example:

In the proposed plan, the number of doctors in New Jersey would nearly double to around 28,000, up from about 15,000. The number of doctors in Connecticut would jump to around 14,000 and the number of doctors in Pennsylvania would grow to more than 49,000.

Members in Florida would have access to 49,000 doctors in the new plan, compared to the 4,000 in the current plan.

In other states like Georgia, Arizona, California, Virginia and North Carolina, there are currently only several hundred in-network doctors in each state under the GHI CBP plan. Under NYCE PPO, each of those states would have tens of thousands of in-network doctors. For example, Arizona would have about 21,000 in-network doctors, North Carolina would have about 32,000, and California would have about 80,000.

Could I see doctors outside New York or while traveling without a referral?

Yes. The NYCE PPO is a true national PPO, which means you would be able to see in-network doctors anywhere in the country without a referral. You do not have to live in a particular location to see a provider. This flexibility would also apply if you are traveling or on vacation, so you can access care without needing to switch your primary doctor or get special approval. This larger nationwide network of providers would also benefit dependents who are living out of state such as children in college.

Would I need to designate a primary care provider?

No, a primary care provider would not be required with this plan.

Prescription drugs

Would anything change with our prescription drug coverage?

Prescription drugs for in-service members through Welfare Funds:

In-service members receive most of their prescription benefits through their Welfare Fund. The Welfare Funds prescription drug program would not be affected by the proposed city health plan.

In-service members who receive other prescription drugs through their city health plan, including Affordable Care Act and New York State-mandated drugs such as diabetes medication and birth control, would still receive those drugs under the proposed health plan through the city's new pharmacy benefit manager, Prime Therapeutics (which is replacing Express Scripts for Pre-Medicare retirees and ACA/NYS mandated drugs in this plan).

Prescription drugs for pre-Medicare retirees:

Pre-Medicare retirees who receive their prescription benefit by purchasing an optional rider would be covered under the new NYCE PPO through the new plan's pharmacy benefit manager, Prime Therapeutics. There will continue to be a mail order service available.

What would the cost be for the pre-Medicare retiree optional prescription rider under the new plan?

The cost would be comparable to what it is now, but the exact cost has not yet been determined. The cost of the optional rider is generally set twice a year based on utilization across the plan. The cost of this rider typically increases a small amount each year depending on utilization patterns (prescription types, amount of claims and costs of the prescriptions used that year by all members of the plan). Cost determinations are usually made at the beginning of January and July, so at this point we cannot provide a specific figure, but the increase will not be a drastic change.

Expansion of drugs covered by NYCE PPO

- +20,000 (40%) more medications in the formulary as Prime Therapeutics would replace Express Scripts as the Pharmacy Benefit Manager (PBM).
- 98% of prescriptions currently filled by pre-Medicare retirees in the GHI CBP plan would still be covered, with only 2% having to change to an alternative medication.

- 99% of prescriptions currently mandated by the Affordable Care Act and NYS law (e.g., diabetic drugs) would still be covered, with only 1% having to change to an alternative medication.
- Prime Therapeutics would allow for a customized formulary and a way to tweak it as needed, which can't be done under the current plan without impacting the cost.
- Prime Therapeutics does not own retail or mail order pharmacies, meaning it can shop around for the best prices, rather than directing business to its own inventory.

Would I need to get new prescriptions for my existing medications once I am enrolled in the new plan?

No, your prescriptions currently covered under the GHI CBP plan would all be transferred to the new NYCE PPO for you.

I currently use PICA for certain specialty drugs. Would anything change?

The NYC PICA prescription drug benefit program, administered by Express Scripts, is not changing at this time.

Prior authorizations

What is prior authorization?

Prior authorization is when a health care provider, such as a doctor or hospital, receives approval from your health plan before performing certain diagnostic tests or performing a medical procedure. Prior authorizations are safeguards used to make sure procedures prescribed by doctors and hospitals are safe and effective, are being provided in the right care setting and follow all nationally recognized medical guidelines.

Does my current GHI CBP plan require prior authorizations?

Yes, the GHI CBP plan has always required prior authorizations for certain procedures and services.

Would the proposed NYCE PPO require prior authorization in certain cases?

Like the GHI CBP plan, the proposed NYCE PPO would also require prior authorizations for certain procedures and services.

How would the prior authorization process in the new plan differ from our current plan?

EmblemHealth and UnitedHealthcare would now internally manage the prior authorization process, rather than relying on a third-party vendor as it does under the current system in the GHI CBP plan.

In the proposed health care plan, fewer procedures and services would require prior authorization.

- In the new plan, prior authorizations would decrease by 50%
- If this change had been in place in the GHI CBP plan last year, 461,911 claims would not have required prior authorization and 223,036 patients would not have been subject to prior authorization for certain services.
- Prior authorizations in the current plan that were removed include some of the most frequently used services like MRIs, CT scans, orthopedic surgeries, office-based dermatology, pain injections and home health visits.
- Because of emerging technology such as genetic and molecular testing, some prior authorizations will always be required, and services and procedures are constantly being added or removed from the list requiring prior authorization.

- To ensure members have access to the care they need, a review committee will be set up to monitor this list and work to keep the procedures our members most commonly need off the list.

What would the review committee do?

- A review committee, made up of members from EmblemHealth, UnitedHealthcare, the city and the MLC, would meet monthly to review reports on plan implementation and data trends on issues including costs, prior authorization and claim denials.
- If any issues arise, they will be sent to a mediator to be resolved.
- If there is no resolution through mediation, any dispute would be sent for an expedited arbitration process.

What protections are in place to make sure prior authorization is determined in an appropriate and timely manner?

The providers would regularly monitor how decisions are made, how quickly the approval process happens, how often care is approved and how well it supports your health care needs. EmblemHealth/UnitedHealthcare has committed to:

- **Fast Medical Review:** All prior authorization requests would be reviewed by trained medical experts using established guidelines and research. Many times this review would occur automatically through an online portal, resulting in an instant approval.
- **Appeal Rights:** If a prior authorization request were denied, it would not necessarily mean the care won't be approved. It would just mean the insurer needs more information, believes the request may not be medically necessary or may suggest a more appropriate alternative. The insurance plan would inform you and your provider about how to appeal the decision and other available options.
- **Appeal Process:** If you appeal a decision, your provider could help by sharing more details about why the care is needed. If the decision still was not approved after this second review, you might be able to request an external review in which an independent medical expert — someone not connected to your health plan — would review your case. These experts help make sure decisions are based on established medical guidelines and research.
- **Additional support:** If you want to appeal a decision, the NYCE PPO plan would provide direct support to you. This support includes fully explaining why they denied the request and helping you gather additional information that might support your appeal.

- **Transparency:** The process and policies would be publicly available on the plan's website, so you fully understand how they approach prior authorization.

If I am currently receiving treatment, would I need to get new prior authorizations with this plan?

No, prior authorizations that were approved under the GHI CBP plan would all be transferred to the new NYCE PPO for you.

I've seen things online about UnitedHealthcare and claim denials. Should I be worried about claims being denied more often?

No. This was something the negotiating committee was laser focused on. They took into consideration where and how most claims denials arise and made sure to add protections when negotiating this plan.

Our protections include:

- The projected reduction of prior authorizations by 50% given the reduced number of procedures and services requiring prior authorization, which eliminates many of the upfront hurdles where claim denials occurred.
- The expansion of the provider network means fewer "out-of-network" situations — another common source of claim denials in the GHI CBP plan.
- Monthly joint oversight meetings involving the city, the unions and the insurance companies to track any concerning trends and quickly address issues , including through an expedited binding arbitration process to resolve disputes
- Our individual appeals process makes sure that members have a right to appeal any denials and that cases are reviewed fairly.
- EmblemHealth will do all prior authorizations in the Downstate 13 counties in New York State, which represents 90% of claims.
- UnitedHealthcare, which will process the remaining 10% of claims, will follow the exact same standards that EmblemHealth adheres to, ensuring that prior authorizations are handled uniformly nationwide.

Remember, every major insurance company, even our current Anthem/Blue Cross Blue Shield, has high denial rates nationally. But here in New York City, city workers don't experience those rates of denial. Because of our size, and how we bargain and enforce union protections, no city employee ever needs to engage in a fight with a giant health care system alone.

The bottom line: This plan was carefully negotiated to ensure fairness, reduce prior authorizations, reduce denials and give you strong protections against any unfair denials.

Deductibles & out-of-pocket maximums

What is a deductible?

A deductible is a fixed amount a member must pay during a given time period, usually within a calendar year, before their health insurance benefits begin to cover the costs of their care.

Do we currently have deductibles in our GHI CBP plan and would our deductibles change under the proposed plan?

For **in-network care**, there is no deductible in the GHI CBP plan with the exception of durable medical equipment. That would not change in the new plan.

For **out-of-network care**, there is a $200 deductible in the GHI CBP plan for individuals and $500 deductible for families. That deductible would also remain the same in the new plan.

Would the out-of-pocket maximum change in the proposed new plan?

The total out-of-pocket maximum would not change. Because EmblemHealth/UnitedHealthcare would provide both medical and hospital coverage, there will now be one in-network out-of-pocket maximum, instead of it being split into two like the current bifurcated plan. This maximum for both medical and hospital coverage will remain a total of $7,150 for individuals and $14,300 for families.

Would the out-of-pocket maximum change in the proposed new plan?

The total out-of-pocket maximum would not change. Because EmblemHealth/UHC would provide both medical and hospital coverage, there will now be one in-network out-of-pocket maximum, instead of being split into two like the current bi-furcated plan. This maximum will remain a total of $7,150 for individuals and $14,300 for families,

Out of network:

In both the GHI CBP plan and the new plan, there is no out-of-pocket maximum for out-of-network services.

In-network:

Under the new plan, the total out-of-pocket maximum would remain the same, but the hospital and doctor deductibles would be combined.

How does the out-of-pocket maximum affect me?

The out-of-pocket maximum affects less than .01% of all people in the plan each year. For example, in 2024, of the 750,000 people enrolled in the GHI CBP plan, only 35 of them reached the hospital maximum and only 29 reached the doctor maximum.

What other protections does the NYCE PPO Plan offer?

The new plan continues to include several built-in protections for specialty services:

- Hospital and skilled nursing stays would be capped at $300 per stay, with a combined annual cap of $750.
- Dialysis copays would be capped at $200 per year.

Other health plan information

Would I need to enroll in the new plan if it is approved?

The NYC Employees PPO Plan would replace the GHI CBP plan (formally, the EmblemHealth GHI CBP/Anthem BlueCross and BlueShield plan). If you're an active member of the EmblemHealth GHI CBP plan, you and your eligible dependents would be automatically enrolled in the NYC Employees PPO Plan on Jan. 1, 2026, if the new plan is approved. There would be no gap in coverage, allowing for seamless and continuous care.

What happens to the current GHI CBP plan?

If the new plan is approved, the GHI CBP plan would cease to exist as of Jan. 1, 2026.

Would other city health plans still be available?

Yes, all other current New York City health plans, such as HIP HMO, would continue to be available and would not be affected by the new plan.

What if I am not currently enrolled in GHI CBP but would like to switch to this new plan?

There will be an open enrollment period for health care in November as there is every year. City employees may use this time to switch between any of the city's available health plans including the NYCE PPO, if it is approved.

Does this change affect Medicare-eligible retired members who are enrolled in the GHI Senior Care Plan?

No, if you are enrolled in the GHI Senior Care Plan, you would remain in your current health plan with no changes. If a retiree enrolled in GHI Senior Care has dependents who are not Medicare-eligible and who are enrolled in GHI CBP, those dependents would be automatically transferred to the new plan.

As an extra layer of protection I have been purchasing an optional rider to cover out-of-network emergency hospital reimbursement. Is this still needed?

This rider will no longer be needed or available as the plan has added so many new providers. With over a million new in-network providers across the country the need to use out-of-network hospitals is virtually eliminated.

Is it common for members to have access to a health care contract before it is signed?

No. A health plan contract is a vendor contract between an employer and the insurance carrier. Because the city is the employer in this case, these documents are not circulated to

individual employees before they are signed. People who are insured can see their health plan design and benefits, which is exactly what has been made available to all union members, providing an unprecedented level of transparency and detail about the proposed plan.

In addition, a plan comparison chart was created at the request of the MLC. This chart compares the current benefits in the GHI CBP plan with the proposed NYCE PPO benefits so members can clearly see what would change, providing details beyond what a contract alone contains.

Can changes be made to this plan by the city or health care company without MLC approval?

No. Any change must be approved by the MLC first. That means the city cannot unilaterally increase your costs or reduce your coverage. Like all agreements, changes can happen, but since all changes require union approval, we can say "yes" to good changes (like lowering a copay) and "no" to bad ones.

So bottom line—what does this mean for me?

It means you are protected. The union holds veto power. No one can make changes that hurt members without our consent. At the same time, this flexibility lets us approve improvements to your benefits more quickly when opportunities arise.